



NEW APPLICANTS

VOLUNTARY WAIVER OF HEALTH INSURANCE COVERAGE - CITY OF BOSTON 2013 ENROLLMENT

Last Name	First Name	Employee Number
Name of Alternate Health Insurance Coverage		Subscriber's Relationship to You

You must attach a letter of Verification of Alternate Coverage on Employer or Group Letterhead and signed by an authorized representative with your Application to receive the opt-out payment.

- I hereby acknowledge that I have been advised of my right to have health insurance coverage through the City of Boston. Having been so advised, I do hereby waive my right to health insurance coverage and/or cancel my health insurance coverage through the City. I also authorize the City to cancel my existing health insurance coverage (if applicable) as of July 1, 2013 or as of the effective date of my alternative coverage - whichever date is later.
- In return for my agreement to waive health insurance coverage, the City agrees to pay me \$1,000.00 or \$1,500.00 annually for waiving my individual health insurance plan or \$1,500.00 or \$2,500.00 annually for waiving my family health insurance plan (whichever applies under my collective bargaining unit agreement), for each year that I voluntarily agree to waive health insurance coverage through the City.
- I hereby certify that there is no outstanding court order or agreement requiring me to provide health insurance coverage for my spouse and dependent children, if any.
- I understand that the City of Boston is not responsible for my medical coverage effective on July 1, 2013 or as of the effective date of my alternative coverage - whichever date is later (except for medical coverage for injuries and illnesses covered by M.G.L. c. 41, § 111F or M.G.L. c. 152 and/or applicable collective bargaining provisions) and for each fiscal year thereafter that I voluntarily agree to waive health insurance coverage through the City.
- I hereby acknowledge that I may only obtain health insurance through the City in the future, other than during the open enrollment period in 2014, if my alternate health insurance coverage is canceled, lost or otherwise terminated and I provide documentation of such event to the City's Health Benefits Office **within thirty (30) days** of the cancellation of coverage. I also agree that I must repay to the City a prorated amount of the annual opt-out payment to reflect the period for which I will receive health insurance from the City.
- I acknowledge that I have read and understand the information contained on both sides of this waiver form concerning the terms and conditions of the City's voluntary opt-out program.

IF NOT CURRENTLY ENROLLED – Name of City sponsored health plan that you canceled	Date of Cancellation
Signature of City of Boston Employee	Date

IF YOU ARE COVERED UNDER ANOTHER MEDICAL PLAN OUTSIDE OF THE CITY OF BOSTON'S GROUP COVERAGE, YOU MAY WAIVE COVERAGE AND RECEIVE AN ANNUAL OPT-OUT PAYMENT THROUGH YOUR PAYCHECK.

ELIGIBILITY

- To participate, employees must currently be enrolled in medical coverage through the City of Boston and drop the coverage during the Open Enrollment period for at least one year; or your collective bargaining agreement states that you qualify because you had City of Boston health insurance coverage for at least one year during your employment with the City and had previously dropped the coverage.
- Employees are eligible for the payment if they have coverage under another plan. Other plans include:
 - Your spouse's/ partner's plan (as long as he or she is covered by someone other than the City of Boston, Boston Water & Sewer Commission or the Boston Public Health Commission);
 - A private plan;
 - A plan offered through a second employer (if you have another job that provides health care benefits); or
 - A retiree health plan from an employer other than one of the City of Boston groups.

ANNUAL OPT-OUT PAYMENT AMOUNT

- The annual opt-out payment amount is \$1,000.00 or \$1,500.00 annually for waiving an individual health insurance plan or \$1,500.00 or \$2,500.00 annually for waiving a family health insurance plan (whichever applies under your collective bargaining agreement).
- The opt-out payment will be issued as a lump sum in one of your payroll checks.

Please note that amounts you receive under this plan are subject to federal, state, and medicare taxes.

APPLYING FOR THE ANNUAL OPT-OUT PAYMENT

- The City of Boston wants you to stay on the road to good health. Therefore, if you choose to waive medical plan coverage, you must certify that you have coverage under another medical plan by:
 1. Completing and signing a "Waiver of Health Insurance Coverage" application; and
 2. Providing written documentation of your other coverage on employer or group letterhead signed by an authorized representative of the employer or health insurance group providing the alternative coverage; and
 3. Copy of your marriage certificate or one of your dependent's birth certificate, **if you are applying for the family benefit for the first time.**
- Your "Waiver of Health Insurance Coverage" application is found on the reverse side of this form.
- If your alternate coverage is not effective until after July 1, 2013, you can still choose to waive your City health insurance plan provided that you submit a health insurance waiver application and proof of your alternate coverage on or before May 8, 2013. You must also maintain your City medical plan coverage until your alternate plan becomes effective. Please note that if your alternate coverage is not effective until after July 1, 2013, you will receive a prorated opt-out payment following the effective date of your alternate coverage.

WHEN TO SUBMIT YOUR WAIVER APPLICATION

- All waiver applications must be completed between the period of April 3, 2013 to May 8, 2013.
- All waiver applications must be returned to the Health Benefits Office in Room 807, City Hall by May 8, 2013.

IF YOU WAIVE COVERAGE AND NEED TO REJOIN THE CITY OF BOSTON HEALTH INSURANCE PROGRAM

If you waive coverage and then lose your other coverage during the City of Boston's medical plan year, you can rejoin the plan, but you must:

- Notify the City of Boston within **thirty (30) days** of the date of insurance cancellation;
- Provide verification of loss of coverage; and
- Enroll in a medical plan offered by the City

If you do not enroll in a City health plan within the 30 days, the City of Boston will not be responsible for any medical claims you incur after your loss of other coverage and you must wait until the next Open Enrollment period to reapply for coverage.

REPAYMENT OF CASH BENEFIT PAYMENT

If you waive coverage, receive your cash benefit, and then rejoin the City of Boston's medical plan at a later date, you must pay back a certain amount of the annual opt-out payment. The amount you pay back will be prorated to reflect the period for which you received payment minus the number of months that you will now be covered by one of the plans offered by the City of Boston.

FOR MORE INFORMATION

For more information on the Cash Benefit Incentive Program, please call the Health Benefits Office at (617) 635-4570.